

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-028662

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No.

318

Primary Registration District No.

1003

Registrar's No.

7192

STATE FILE NUMBER

1. PLACE OF DEATH JUL 31 1962

a. COUNTY

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)

a. STATE Missouri b. COUNTY St. Louis

b. CITY (If outside corporate limits, give TOWNSHIP only)
OR TOWN St. Louis

Length of stay in 1b

c. CITY OR TOWN Chesterfield

Inside Limits
Yes ☐ No ☐c. FULL NAME OF (If NOT in hospital, give location)
HOSPITAL OR INSTITUTION St. Lukes HospitalInside Limits
Yes ☒ No ☐d. STREET ADDRESS (If outside, give location)
Rt #2 Box 175Reside on Farm
Yes ☐ No ☐3. NAME OF DECEASED
(Type or print)

First SAMUEL

Middle MORRIS

Last GEISINGER

4. DATE OF DEATH

Month July

Day 21

Year 1962

5. SEX male

6. COLOR OR RACE white

7. Married ☒ Never Married ☐
Widowed ☐ Divorced ☐

8. DATE OF BIRTH 11/20/1908

9. AGE (last birthday) 53

IF UNDER 1 YEAR IF UNDER 24 HR
Months Days Hours Min.10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
teacher10b. KIND OF BUSINESS OR INDUSTRY
Howell High School11. BIRTHPLACE (City and state or country)
St. Louis, Mo12. CITIZEN OF WHAT COUNTRY
U.S.A.

13a. FATHER'S NAME

Samuel L. Geisinger

13b. MOTHER'S MAIDEN NAME

Mae L. Newman

14. NAME OF HUSBAND OR WIFE

Nesta K. Geisinger

15. WAS DECEASED EVER IN U.S. ARMED FORCES?

(Yes, no, or unknown) (If yes, give war or dates of service)
no

16. SOCIAL SECURITY NO.

17. INFORMANT

Address

Mrs. Nesta Geisinger Box 175 Rt #2

Chesterfield, Mo

INTERVAL BETWEEN ONSET AND DEATH
Few Weeks

18. CAUSE OF DEATH (Enter only one cause per line for PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Cancer of the Lung

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

DUE TO (b)

DUE TO (c)

163x

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)

PART III. If deceased was female was there a pregnancy in last 90 days.

☐ Yes ☐ No ☐ Unknown19. WAS AUTOPSY PERFORMED?
YES ☒ NO ☐20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)

20c. TIME OF INJURY Hour Month, Day, Year
a.m. p.m.20d. INJURY OCCURRED WHILE AT WORK ☐
NOT WHILE AT WORK ☐

20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

20f. CITY, TOWN, OR LOCATION

COUNTY

STATE

21. I attended the deceased from 1957 to present and last saw him alive on 7/21/62
Death occurred at 7:30 am on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE

(Degree or title)

John Davidson MD

22b. ADDRESS

600 Union Blvd

22c. DATE SIGNED

7/23/62

23a. BURIAL, CREMATION, REMOVAL (Specify)

removal

23b. DATE

7/23/62

23c. NAME OF CEMETERY OR CREMATORY

Oak Grove Cemetery

23d. LOCATION (City, town, or county)

St. Louis County, Missouri

24. FUNERAL DIRECTOR

ADDRESS

Lupton Chapel Inc 7233 Delmar Blvd

25. DATE RECD. BY LOCAL REG.

JUL 23 1962

26. REGISTRAR'S SIGNATURE

Carol Smith M.D.

USE BLACK INK

OR
TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

SHOULD READ

INSTEAD OF

DATE AMENDED

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

VS 300
Rev. 4/59

1

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4 0

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12 81-0

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81

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Arnold W. Schoene

Licensed Embalmer No. 3864

P. O. Address St. Louis, Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.